Statistical Bulletin

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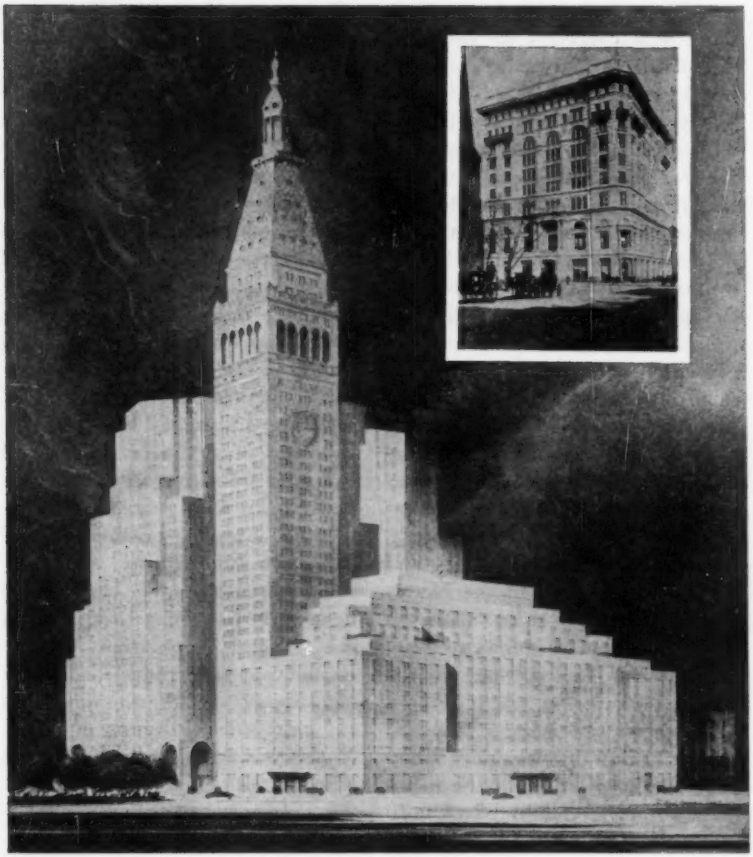

The Home Office as it will appear in 1960.

Inset: Original Home Office building, on the site now adjoining the Tower.

Ninety Years of Progress

On March 24 the Metropolitan Life Insurance Company celebrates its 90th birthday. When the Company was launched in 1868, the flag of the United States displayed but 37 stars and Canada had only one year earlier achieved Dominion status. In the intervening years far-reaching developments have taken place in both countries, the most significant of which have been marked advances in the health, welfare, and financial security of the people. The Metropolitan is proud of the active role it has played over the years in furthering these objectives through its broad program of Health and Welfare activities and by bringing the benefits of Life insurance to an ever-increasing number of people. Currently more than 41 million individuals in the United States and Canada are insured in the Metropolitan; this is over one fifth the present population of the two countries and close to their total population in 1868.

The past 90 years have witnessed greater gains in longevity than have all the prior centuries of human history. Available data indicate that the average length of life in the United States at the time the Metropolitan was established was about 45 years. At present the average is approximately 70 years. Even more spectacular than the gains in longevity for the population as a whole have been those achieved by wage-earners and their families. The average length of life among the Company's Industrial policyholders was only 34 years in 1879-94; the figure has more than doubled and is now on a par with that for the general population. Under current mortality conditions, there are as many years of life remaining to Industrial policyholders at age 40 as there were to a child born into a wage-earning family in the 1880's.

The outstanding achievement of medicine and public health in our time has been the control gained over the infectious diseases. Even at the turn of the century the infectious diseases—pneumonia and influenza, tuberculosis, and diarrhea and enteritis, in that order—headed the list of causes of death in the general population of the United States. Incredible as it may seem now, diphtheria was then among the first 10 causes of death. As these diseases continued to take a heavy toll of life, the Metropolitan, among its many welfare activities, pioneered in demonstrating how they could be brought under control. The now classic demonstration in Framingham, Mass.,

supported by the Company, showed how the tuberculosis problem could be drastically reduced. The Influenza-Pneumonia Commission, organized and financed by the Company, helped to develop pneumonia sera—at one time the only weapon against the disease—and later contributed to the wide use of the newer drugs which have proved effective in the treatment of pneumonia. In Thetford Mines, Que., the Metropolitan demonstrated how the loss of infant life could be greatly diminished. At present the tuberculosis death rate in the United States is about 8 per 100,000, compared with 194 in 1900; mortality from influenza and pneumonia decreased from 202 per 100,000 to little more than 35 in 1957, even though influenza was widely prevalent last year; the infant mortality rate is down to about 26 per 1,000 live births, or to only one fifth the level at the turn of the century.

The rise of the Metropolitan to eminence in its field parallels the rapid growth of population in the two countries. There are now nearly 4½ times as many people in the United States as there were 90 years ago, the number having increased from about 38 million to more than 173 million. Canada experienced an even more rapid population growth during this period —from approximately 3½ million to 17 million. Particularly impressive have been the gains of recent years. For more than a decade, the population increase in the United States has exceeded 2½ million a year. Largely as a result of the sustained baby boom, more than 22 million have been added to the population of the country since the 1950 Census. Each of the past seven years has established a new high record for births, the number passing the 4,300,000 mark last year. Not alone recently but also historically, natural increase—the excess of births over deaths—has been the primary source of our population growth; immigration has played a subordinate part, even in the decade prior to World War I, when the influx of immigrants was at its peak.

The years ahead give promise of continued population growth. A decade hence, when the Metropolitan marks its centennial, the population of the United States may reach 200 million. From all indications, large increases will occur in the number of dependent children, the population at ages 65 and over, and the number of widows. It is these segments of the population that are the major beneficiaries of the benefits provided by Life insurance. As the American people continue to make provision for their future needs, they strengthen the foundations of both family life and the national economy. It appears at this milestone in the Company's history that the people of the United States and Canada can look forward to further gains in financial security.

Recent Population Growth in Large Cities

SINCE the 1950 Census, the population of the United States as a whole has been increasing at the rate of about 1.7 percent a year. Growth has been most rapid in the outlying parts of the standard metropolitan areas — primarily the newly developed suburbs—where the gain has been about 4½ percent annually. On the other hand, the rate of population increase in the large cities as a group has been below the national average. The details for 70 of the 106 cities with 100,000 or more residents in 1950 are shown in the accompanying table; the cities listed are those for which recent reliable population data are available.

In most large cities in the Northeast, population either has grown slowly—less than 1 percent a year —or has actually decreased. All the larger cities in Massachusetts, except Springfield, have lost population since 1950; the annual decrease has been as much as 4.3 percent in Cambridge and 2.1 percent in Boston. New York City's population declined from 7,892,000 in 1950 to 7,795,500 in 1957, or 0.2 percent a year.

With one exception, the large cities of the North Central area have been adding to their population since 1950; the exception is St. Louis, Mo., where the decrease has been only 0.3 percent a year. Most cities in the North Central States, unlike the pattern elsewhere, have grown more rapidly during the 1950's than in the prior decade. The acceleration has been particularly marked in Ohio. The population of Youngstown, which remained practically unchanged between 1940 and 1950, has increased 1.2 percent a year since the 1950 Census. Cincinnati, Columbus, Toledo, and Dayton likewise have quickened their rate of growth. Although population gain has been almost universal in the large cities of the North Central region, the rate of gain in the majority of them has been less than that for the country as a whole.

Most of the rapidly growing large cities are in the South and the West. In five of them the population gain since 1950 has exceeded 3½ percent a year, which is more than twice the national rate of growth. San Diego has experienced a larger relative gain than any of the other cities included in this study, its population increasing 5.7 percent a year between 1950 and 1957—from 334,400 to 494,200. In Atlanta, Mobile, Norfolk, and Denver the annual increase ranged from 5.5 to 3.7 percent. The only other cities in the country with annual rates of increase of this magnitude are Wichita (5.6 percent) and Gary (3.7 percent), both of which are in the North Central region.

Throughout the United States the suburbs and rural communities

POPULATION CHANGES IN SELECTED AMERICAN CITIES, 1940-1957

Region and City	April 1, 1958		1955 or Later		Annual Percent Increase‡	
	Rank†	Population (1,000's)	Population (1,000's)	Date	Since 1950	1940-1950
Northeast						
New York, N. Y.	1	7,892.0	7,795.5	4- 1-57	−0.2	0.6
Philadelphia, Pa.	3	2,071.6	2,160.0	7- 1-56	.7	.7
Boston, Mass.	10	801.4	724.7	1- 1-55	−2.1	.4
Buffalo, N. Y.	15	580.1	597.5	7- 1-57	.4	.1
Newark, N. J.	21	438.8	462.1	7- 1-55	1.0	.2
Rochester, N. Y.	32	332.5	347.3	7- 1-57	.6	.2
Jersey City, N. J.	37	299.0	308.8	7- 1-55	.6	— .1
Providence, R. I.	43	248.7	223.0	7- 1-56	−1.7	— .2
Syracuse, N. Y.	47	220.6	214.3	4- 1-57	— .4	.7
Worcester, Mass.	50	203.5	202.6	1- 1-55	— .1	.5
Hartford, Conn.	54	177.4	187.4	7- 1-57	.8	.7
New Haven, Conn.	59	164.4	165.8	7- 1-57	.1	.2
Springfield, Mass.	61	162.4	166.1	1- 1-55	.5	.8
Bridgeport, Conn.	63	158.7	166.1	7- 1-57	.6	.8
Yonkers, N. Y.	64	152.8	178.1	4- 1-57	2.2	.7
Paterson, N. J.	66	139.3	146.6	7- 1-55	.3	— *
Albany, N. Y.	68	135.0	142.6	7- 1-57	.8	.3
Trenton, N. J.	79	128.0	134.9	7- 1-55	1.0	.3
Camden, N. J.	85	124.6	132.1	7- 1-55	1.1	.6
Cambridge, Mass.	86	120.7	99.0	1- 1-55	−4.3	.9
Elizabeth, N. J.	91	112.8	119.8	7- 1-55	1.1	.3
Fall River, Mass.	92	112.0	105.2	1- 1-55	−1.3	— .3
New Bedford, Mass.	96	109.2	105.5	1- 1-55	— .7	— .1
North Central						
Chicago, Ill.	2	3,621.0	3,745.0	7- 1-56	.5	.6
Detroit, Mich.	5	1,849.6	1,912.0	7- 1-57	.5	1.3
Cleveland, Ohio	7	914.8	941.1	7- 1-57	.4	.4
St. Louis, Mo.	8	856.8	841.0	1- 1-56	— .3	.5
Milwaukee, Wis.	13	637.4	714.0	7- 1-57	1.6	1.8
Minneapolis, Minn.	17	521.7	551.0	4- 1-56	.9	.6
Cincinnati, Ohio.	18	504.0	562.6	7- 1-57	1.5	1.0
Indianapolis, Ind.	23	427.2	455.3	7- 1-56	1.0	1.0
Columbus, Ohio.	28	375.9	450.9	7- 1-57	2.5	2.1
St. Paul, Minn.	35	311.3	338.9	4- 1-56	1.4	.8
Toledo, Ohio.	36	303.6	335.1	7- 1-57	1.4	.7
Akron, Ohio.	39	274.6	299.1	7- 1-57	1.2	1.2
Omaha, Nebr.	40	251.1	280.4	7- 1-56	1.8	1.2
Dayton, Ohio.	44	243.9	291.1	7- 1-57	2.5	1.5
Des Moines, Iowa	53	178.0	194.7	7- 1-56	1.4	1.1
Youngstown, Ohio	57	168.3	182.9	7- 1-57	1.2	*
Wichita, Kans.	58	168.3	244.7	3- 1-57	5.6	3.9
Gary, Ind.	70	133.9	168.9	8-18-56	3.7	1.8
Fort Wayne, Ind.	71	133.6	144.9	11- 9-56	1.2	1.2
Kansas City, Kans.	76	129.6	131.3	3- 1-57	.2	.6
Evansville, Ind.	78	128.6	138.5	7- 1-56	1.2	2.9
South Bend, Ind.	89	115.9	131.8	9-20-57	1.7	1.4
Peoria, Ill.	93	111.9	118.0	7- 1-56	.9	.6
South						
Baltimore, Md.	6	949.7	979.0	7- 1-57	.4	1.0
Washington, D. C.	9	802.2	831.0	7- 1-57	.5	1.9
Houston, Tex.	14	596.2	711.0	1- 1-56	3.1	4.5
New Orleans, La.	16	570.4	602.0	7- 1-56	.9	1.4
Atlanta, Ga.	33	331.3	488.4	7- 1-57	5.5	.9
Birmingham, Ala.	34	326.0	356.3	7- 1-56	1.4	2.0
Miami, Fla.	42	249.3	260.2	7- 1-56	.7	3.8
Richmond, Va.	46	230.3	237.2	7- 1-57	.4	1.8
Norfolk, Va.	48	213.5	291.0	7- 1-57	4.4	4.0
Mobile, Ala.	77	129.0	173.8	7-18-56	4.8	5.1
Savannah, Ga.	87	119.6	137.0	7- 1-57	1.9	2.2
Wilmington, Del.	94	110.4	114.4	7- 1-56	.6	−.2
West						
Los Angeles, Calif.	4	1,970.4	2,333.8	7- 1-57	2.4	2.7
San Francisco, Calif.	11	775.4	776.0	7- 1-57	*	2.0
Seattle, Wash.	19	467.6	572.0	4- 1-57	2.9	2.4
Denver, Colo.	24	415.8	520.5	7- 1-56	3.7	2.6
Portland, Ore.	29	373.6	412.1	7- 1-57	1.4	2.0
San Diego, Calif.	31	334.4	494.2	3-30-57	5.7	5.1
Long Beach, Calif.	41	250.8	309.3	7- 1-57	2.9	4.3
Spokane, Wash.	62	161.7	187.0	4- 1-57	2.1	2.9
Tacoma, Wash.	65	143.7	157.0	4- 1-57	1.3	2.8
Sacramento, Calif.	67	137.6	158.0	7- 1-56	2.2	2.6
Berkeley, Calif.	90	113.8	116.0	7- 1-56	.3	2.9
Pasadena, Calif.	101	104.6	119.4	7- 1-57	1.8	2.5

* Less than 0.05 percent. † National rank, including cities not shown.
‡ Geometric average annual rate. Minus sign (—) denotes decrease.
Source of basic data for 1955 or later: Special censuses and estimates by the Bureau of the Census and by State and local agencies.

adjacent to large cities have continued to grow at a faster pace than the cities themselves. For example, the city of Los Angeles has increased its population 2.4 percent annually since 1950, yet its share of the population in the Los Angeles-Long Beach metropolitan area has declined from 45.1 percent in April 1950 to 38.2 percent in July 1957. Even San Diego, with its high rate of growth, has not kept pace with the gains in its surrounding territory, the increase in the latter exceeding 1½ times the rate in the central city.

The drift to the suburbs is a natural outcome of urban growth and development. As the central parts of cities are increasingly occupied by commercial and industrial enterprises, the population shifts first to outlying neighborhoods and later moves beyond the city boundaries. In New York City, for example, the population losses in the 1950's have been restricted largely to the older areas of the city. By contrast, the outlying boroughs of Richmond and Queens have continued to gain residents. Even more impressive have been the increases in the areas outside the city. Thus, Nassau County increased its population from 673,000 in 1950 to about 1,180,000 in 1957 and Suffolk County virtually doubled its population, while Westchester and Rockland Counties also scored substantial gains.

Health and Accident Hazards in Industry

AMONG the many achievements of American industry are its successful efforts to control the health and accident hazards arising out of gainful employment. The toll taken by occupational disease and injury in the United States has been greatly reduced, but the loss of life and limb is still large. Moreover, as new processes and materials are developed, they may, and occasionally do, bring with them new potential hazards.

Silicosis, long an important source of disability in industry, continues to be an appreciable problem although much has been accomplished in the prevention of the disease through dust-control measures. In a recent study the Public Health Service found that 10,362 cases of silicosis had been reported in 22 States during the five-year period 1950-54, and notes that this total probably underestimates the actual number. The large majority of these victims had contracted the disease many years ago—before adequate control measures were instituted—but an appreciable number of cases were found among younger men with relatively recent exposure to silica dust in mining and in various manufacturing industries.

Effective measures have been taken by many industries to reduce or to prevent exposure of workers

to toxic substances. A classic example is the discontinuance of the use of mercury in the manufacture of felt hats, which virtually eradicated an old and significant cause of industrial illness. Similarly, lead poisoning has largely been brought under control. Workers employed in the production of white lead have been protected by reduction of the dust hazard, better medical supervision, and other safeguards. People in occupations traditionally using materials containing lead—painters, plumbers, printers, pottery glazers and decorators—have improved their methods of working and personal hygiene, or have substituted other types of material. Nevertheless, there are still a number of lead poisoning cases reported each year. Many more would undoubtedly occur if those employed to blend tetraethyl lead with gasoline and those engaged in the manufacture of storage batteries were not so scrupulously safeguarded.

Little more than a decade ago cases of beryllium poisoning began to occur in increasing number as the use of beryllium compounds expanded, particularly in the manufacture of fluorescent light tubes. Alerted to the new hazard, industry, with the advice of industrial hygiene experts, established effective measures of control, so that where the use of the chemical continues to be feasible, it can be utilized safely. In addition, beryllium has been replaced in the manufacture of fluorescent light tubes. Even though very few new cases of beryllium poisoning are developing, a registry established several years ago at the Massachusetts General Hospital has on its records more than 500 cases of the disease.

The hazards of radiation came dramatically into the news about 30 years ago, when a number of women employed to paint luminous dials on watches were stricken with radium poisoning. The extraordinary developments of the atomic energy industry in recent years, and the prospect of vast future growth, pose many medical and public health problems. While it appears that the activities at the major Atomic Energy Commission installations have had a good safety record, the growing use of radioactive isotopes in industrial plants, laboratories, hospitals, and other places is increasing the number of people exposed to radiation hazard. Maximum protection needs to be given persons working with atomic substances and equipment. The permissible levels for radiation exposure set by government agencies can serve as a guide for the maintenance of safety among workers in this field.

Accidents constitute a serious hazard in a number of occupations. Particularly dangerous is the work of aerialists, automobile racers, experimental test pilots in aviation, caisson workers under high atmospheric pressure, steeple jacks, and flagpole workers.

There is evidence that many of the jobs in the logging industry are fraught with risk of serious injury. United States Bureau of Labor Statistics figures indicate that the average number of days of disability per million man hours is about 10 times as high for loggers as for the manufacturing industries as a whole. Among the most hazardous activities are felling the timber, cutting the felled trees into desired lengths, and hauling the logs to a central point.

Coal mining is a relatively hazardous industry. In the anthracite mines during 1955-56, more than 2 per 1,000 employees a year were killed on the job, according to data from the United States Bureau of Mines. The danger of fatal injuries is particularly great in underground operations.

Pilots who spray, dust, or seed crops from planes are subject to a variety of hazards. It is estimated from data published by the Civil Aeronautics Administration that the on-the-job accident death rate among men engaged in this type of work is no less than 10 per 1,000 annually.

Note: The following were the major sources used in the preparation of this article: "Silicosis Still Prevalent in U. S.," *Safety Standards*, January—February 1958, page 1; annual reports of Work Injuries in the United States, United States Bureau of Labor Statistics; various reports of the United States Bureau of Mines, the Atomic Energy Commission, and the Civil Aeronautics Board; "Beryllium Case Registry," *Public Health Reports*, December 1957, page 1066.

Outlook in Cerebral Vascular Disease

UNTIL recently cerebral vascular disease received relatively little attention from public health authorities, which reflected largely the viewpoint that such conditions were merely a terminal event in the death of old people. However, recent advances in the knowledge and treatment of cerebral vascular disease have tended to modify this attitude.

The National Heart Institute of the Public Health Service estimates that at least 2 million people in the United States are handicapped or incapacitated by the cerebral vascular diseases. These comprise a number of conditions of more or less common etiology, primarily cerebral arteriosclerosis, cerebral hemorrhage, embolism and thrombosis. Mental deterioration is frequently associated with cerebral arteriosclerosis, and many thousands of such cases are admitted to mental hospitals each year.

The cerebral vascular diseases account for about 185,000 deaths a year in the United States, or for nearly 12 percent of the total mortality. Of this number almost two thirds are attributed to cerebral hemorrhage and about one fourth to thrombosis and embolism. Cerebral vascular disease is third among the causes of death, being

MORTALITY FROM VASCULAR LESIONS OF THE CENTRAL NERVOUS SYSTEM
By Color, Sex, and Age. United States, 1955

Age Period (Years)	Death Rates Per 100,000					Percentage			
	Total Persons	White		Nonwhite		Male of Female Rate		Nonwhite of White Rate	
		Males	Females	Males	Females	White	Nonwhite	Males	Females
All Ages*.....	84.2	83.9	74.2	142.3	146.2	113	97	170	197
25-34.....	5.0	4.2	3.5	13.2	15.2	120	87	314	434
35-44.....	16.6	11.6	11.5	60.1	62.9	101	96	518	547
45-54.....	56.0	45.2	40.2	161.5	200.1	112	81	357	498
55-64.....	163.7	157.5	119.8	451.7	463.4	131	97	287	387
65-74.....	562.0	546.4	447.6	979.8	963.8	122	102	179	215
75-84.....	1,522.4	1,594.3	1,493.2	1,344.4	1,258.6	107	107	84	84
85 and over.	3,227.5	3,262.6	3,470.8	1,681.3	1,678.6	94	100	52	48

* Death rates adjusted for age on basis of United States population on April 1, 1940.
Source of basic data: Reports of National Office of Vital Statistics.

outranked only by heart disease and cancer; at ages 65 and over it is second only to heart disease.

The common notion that a cerebrovascular accident (stroke) almost invariably causes immediate death is unwarranted. It is estimated that about one fifth of the victims live a month or more, and that many, with less severe involvement, live for a considerable period.

A prime characteristic of the mortality from cerebral vascular disease is its concentration in later life. In 1955 more than 75 percent of the deaths from this cause were recorded at ages 65 and over, compared with less than 70 percent for heart disease and little more than 50 percent for cancer. As the table on this page shows, the death rate from lesions of vascular origin increases very sharply with advance in age. Thus, among white persons the mortality rate about triples from one decennial age group to the next in the range from 25 to 84 years. White males record a higher death rate than the females in this broad age range; among nonwhites, however, the rate for males exceeds that for females only at ages 65 and over. For each sex the mortality among nonwhites is greater than among whites at all but the oldest age groups; the reversal after age 75 may reflect inaccuracies in reporting of age among nonwhite persons.

The long-term trend in the recorded mortality from vascular lesions of the central nervous system has been downward, but it is difficult to determine whether this trend is real or only apparent. Vas-

cular changes in the brain are usually associated with similar changes elsewhere in the body—notably the heart—and the tendency has increasingly been for physicians to ascribe deaths of this kind to cardiac rather than to cerebral causes. Moreover, a diagnosis of cerebral vascular disease is often of doubtful accuracy, particularly in the many cases where a person dies suddenly or is found dead. It is significant, too, that the proportion of all cardiovascular-renal deaths ascribed to cerebral vascular disease tends to be highest in areas where medical facilities are least abundant.

Hope for improving the outlook in cerebral vascular disease depends primarily upon the initiation of a long-term research program, on the development of new methods of treatment and greater use of the best methods now available. Research on many phases of these diseases has been accelerated recently by the Public Health Service and its National Institute of Neurological Diseases. A development of considerable interest is the treatment of cerebral thrombosis with anticoagulants similar to those used in coronary occlusion. While it is too soon to evaluate this type of therapy, initial success has been reported by some in carefully studied cases. Other new drugs, such as the antibiotics and cortisone, are helpful in relieving symptoms or preventing complications. There is also the possibility of new developments in surgery which may prove of value in selected cases. More intensive use can be made of established means of treatment, such as careful nursing care and early application of physical therapy for rehabilitation of patients.

No specific means of preventing these disorders is available. This must await basic advances in our knowledge of arteriosclerosis and hypertension, which are closely associated with the most common forms of cerebral vascular disease. The newer drugs for relief of hypertension are of some use in the prevention or postponement of these conditions. There is indication, too, that prevention or reduction of overweight may retard the onset and development of vascular changes associated with premature death from cerebral vascular disease.

MORTALITY FROM SELECTED CAUSES
Industrial Policyholders, Metropolitan Life Insurance Company
January 1958

Cause of Death	Annual Rate per 100,000 Policyholders*				
	January		Year		
	1958	1957	1957	1956	1955
All Causes	713.2	676.0	657.1	617.0	620.4
Tuberculosis (all forms)	7.7	7.3	6.7	7.1	7.9
Communicable diseases of childhood	.2	—	.1	.2	.3
Acute poliomyelitis	.3	.1	.1	.3	.6
Malignant neoplasms	138.1	138.0	136.2	128.7	128.2
Digestive system	42.9	47.6	46.9	44.1	45.3
Respiratory system	19.3	19.9	19.0	17.5	16.5
Diabetes mellitus	16.3	14.5	15.2	14.9	14.7
Diseases of the cardiovascular-renal system	387.0	365.6	348.7	328.6	327.7
Vascular lesions, central nervous system	70.3	68.1	66.6	63.4	63.9
Diseases of heart	288.9	270.9	256.2	240.9	239.3
Chronic rheumatic heart disease	12.1	12.5	11.6	11.5	12.0
Arteriosclerotic and degenerative heart disease	230.4	210.5	200.5	187.4	185.0
Diseases of coronary arteries	128.1	121.4	113.8	108.0	107.3
Hypertension with heart disease	35.2	36.0	33.6	33.4	34.0
Other diseases of heart	11.2	11.8	10.5	8.6	8.3
Nephritis and nephrosis	9.0	8.9	8.2	7.6	8.3
Pneumonia and influenza	28.1	20.0	20.0	14.0	14.1
Complications of pregnancy, childbirth	1.1	1.0	.9	.9	1.0
Suicide	4.8	6.2	5.7	5.6	6.1
Homicide	2.9	2.6	2.9	2.4	2.5
Accidents—total	33.5	34.8	34.9	35.6	35.1
Motor vehicle	16.0	15.9	15.3	15.7	15.3
All other causes	93.2	85.9	85.7	78.7	82.2

*The death rates prior to March 1956 relate to persons insured under industrial premium-paying policies and persons with Ordinary Monthly Premium Policies for Less Than $1,000; beginning with March 1956, included also are persons with Debit Book Ordinary policies for $2,000 or less.
Note: The death rates for 1956, 1957, and 1958 are provisional

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